D H E C

PROMOTE PROTECT PROSPER

EMPLOYER COMMUNICATION CONSENT

It may be necessary for the Department of Health and Environmental Control to release or exchange your name, date of birth, and address with your or your spouse's* employer and/or insurance company in order to make health insurance premium payments on your behalf. If you wish to participate in the health insurance premium payment program offered by the Department, you must complete this form, sign it, and have it witnessed by an adult person who knows you.

I, _____, born _____
(Applicant's Name-**Please Print**) (Applicant's date of birth)

and residing at: _____
(Applicant's Address, City, State, and Zip Code)

hereby give permission to the Department of Health and Environmental Control, 3rd Floor Mills/Jarrett, Box 101106, Columbia, SC 29211 to release and/or exchange information with my employer/spouse's employer* and/or insurance company named below for the express purpose of making health insurance premium payments on my behalf.

Further, I give my permission to the employer and/or insurance company named below to release and/or exchange information with the Department of Health and Environmental Control for the express purpose of making health insurance premium payments on my behalf.

Employer/Spouse's Employer*: _____

Employer Address: _____

Employer Contact Person: _____

Employer Contact Person Phone Number: _____

Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone Number: _____

I understand that I may revoke this authorization by notifying the Department of Health and Environmental Control in writing at any time, should I choose to do so.

Applicant Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____
*(*necessary only if Health Insurance premium for applicant is deducted from spouse's payroll check*)

Witness Signature: _____ Date: _____

Witness Name (Printed): _____

Relationship to Applicant: _____